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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was diagnosed with X. Per a peer review dated X, X sustained injuries to the X. X was seen by X, MD on X for a follow-up. X had prior X. X continued to do well. X had minimal pain when the X. X continued to X. X had undergone X appointment a day prior. X reported that X. X stated that at X, they had X. Examination of the X showed a X. Dr. X opined that X was healing well. X continued to have a X. No diagnostic investigations were available in the provided medical records. The treatment to date included X. Per a Peer Review dated X by X, MD, the request was determined to be not medically necessary. Rationale: "The Official Disability Guidelines do not specifically address X. Therefore, outside resources were referenced in this case and have indicated that X. The most common reasons for claimants undergoing X. However, the document did not provide a sufficient overview of the extent of the claimant's X. In addition, the physician did not specify how the claimant's condition was affecting X ability to function on a daily basis, nor was there indication that the procedure would effectively treat the claimant's condition. Given the minimal information, the medical necessity of the request could not be established. As such, the request for X is not medically necessary." A Utilization Review Determination Letter dated X by Dr. X indicated that the recommended prospective request for X was noncertified. Rationale: "The Official Disability Guidelines do not specifically address X. Therefore, outside resources were referenced in this case and have indicated that X. The most common reasons for claimants undergoing X. However, the document did not provide a sufficient overview of the extent of the claimant's X. In addition, the physician did not specify how the claimant's condition was affecting X ability to function on a daily

basis, nor was there indication that the procedure would effectively treat the claimant's condition. Given the minimal information, the medical necessity of the request could not be established. As such, the request for X is not medically necessary." A Peer Review was documented by X, MD on X. The request was determined to be not medically necessary. Rationale: "Documentation on last exam of X revealed claimant previously had X, yet the assessment was not provided in the records. Treatment plan includes continuing with X and a follow-up in X month to discuss future plans for X. The request for X is not medically necessary per ODG guidelines." Per a Reconsideration Review Determination Letter dated X by Dr. X, the prospective request for one reconsideration for X was noncertified. Rationale was as follows: "Documentation on last exam of X revealed claimant previously had X, yet the assessment was not provided in the records. Treatment plan includes continuing with X and a follow-up in X month to discuss future plans for X. The request for X is not medically necessary per ODG guidelines."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Denial is upheld. Request for surgery is noted to be due to a X. However, more documentation is needed regarding the X to establish medical necessity.

Until such documentation can be adequately shown, medical necessity has not been established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- **X MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**